SPECIFICATION

Service	**NHS Health Checks – Pharmacy**
Council Lead	**Helen Bell Public Health Programme Lead**
Provider Lead	**See Contract Particulars**
Period	**1ST April 2022- 31st March 2023**

1. Population Needs

This Specification is intended for pharmacy Staff to provide a standardised approach to delivering the NHS Health Check (NHSHC) Service.

1.1 National/local context and evidence base

The NHS Health Check Programme aims to improve health and wellbeing of adults aged 40-74 years through the promotion of earlier awareness, assessment, and management of the major risk factors and conditions driving premature death, disability and health inequalities in England. CVD is one of the conditions most strongly associated with health inequalities, with death from CVD almost four times higher among people in the most deprived communities compared to those that in the most affluent. The NHSHC provides a systematic mechanism for identifying and managing people with the common risk factors driving CVD, stroke, type 2 diabetes, kidney disease and dementia.

CVD prevention, early detection and management

The NHS Health Check is a systematic vascular risk assessment and management programme to help prevent cardiovascular diseases (CVD) including heart disease, stroke, diabetes, dementia and kidney disease. Local authorities are mandated to commission the risk assessment element of the NHS Health Check programme under the Health and Social Care Act (2012). Where additional testing and follow up is required, for example, where someone is identified as being at high risk of having or developing vascular disease, this remains the responsibility of primary care and will be funded through NHS England.

The NHS Health Check programme aims to:

- improve life expectancy for local people
- reduce the life expectancy gap due to vascular disease between Gateshead and the rest of England through the provision of NHS Health Checks (risk identification, assessment and management) for 40-74 year olds, not previously diagnosed with vascular disease
- promote and improve the early identification and management of the individual behavioural and physiological risk factors for vascular disease and the other conditions associated with these risk factors
- support individuals to effectively manage and reduce behavioural risks and associated conditions through information, behavioural and evidence based clinical interventions

The NHS Health Check Programme offer is for each eligible person aged 40-74 to be offered a NHS Health Check once in every five years and for each person to be recalled every five years if they remain eligible. The national NHS Health Check programme standards (NHS Health

Check Programme Best Practice Guidance, Oct 2019 – Updated March 2020, https://www.healthcheck.nhs.uk/commissioners-and-providers/national-guidance/) specify that:

- The NHS Health Check risk assessment includes specific tests and measurements
- The person having their health check is told and understands their cardiovascular risk score,
- All other results in the NHS Health Check are communicated to the service user,
- Tailored lifestyle advice and behaviour change support is discussed
- Specific information and data is recorded
- Where the risk assessment is conducted outside the Service User's GP practice, for that information to be forwarded to the responsible GP and the GP Practice record this in the patient records.
- That individuals get the lifestyle and clinical follow up needed to reduce their risk of CVD.

Providers will wish to ensure that the NHS Health Check programme they offer is in keeping with the Equality Act 2010. This duty recognises that equality of opportunity cannot be achieved simply by treating everyone the same. Active consideration should be given locally with regard to both access to and delivery of the NHS Health Check for everyone but specifically in respect of those who share one of the nine protected characteristics: age, disability, gender reassignment, pregnancy and maternity, race – this includes ethnic or national origins, colour or nationality, religion or belief – this includes lack of belief, sex, sexual orientation. For example, the way that wheelchair users access their NHS Health Check, as well as how their risk assessment is undertaken and how they are supported to improve their lifestyle will require specific consideration and action.

Data on the performance of the national NHS Programme by regions and local areas can be found here http://www.healthcheck.nhs.uk/commissioners_and_providers/data/. For Gateshead 2013-18 (5 year cumulative) 64,799 people have been offered an NHS Health Check, and 33,585 have received an NHS Health Check. This is 51.8% uptake of people offered who then had an NHS Health Check. In Gateshead, local data is also recorded on outcomes following an NHS Health Check such as lifestyle advice and interventions, risk score, communication of risk, identification of high risk factors and treatment.

The key to optimising the clinical and cost effectiveness of the NHS Health Check programme is to ensure a high percentage of those offered a NHS Health Check receive one. This is especially important for populations with the greatest health needs and will impact on the programme's and local area's abilities to narrow health inequalities. Quarterly feedback is shared with all providers so progress against targets can be monitored.

2. Key Service Outcomes

The service is to be provided in a manner that will contribute to the achievement of the following outcomes:

- Minimum of 120 NHS Health Checks completed over a 12 month period by the Provider
- Hard copy of NHS Health Check results given by the Provider to each Service User
- Copy of NHS Health Check results given by the Provider to General Practitioner ("GP") for each of their Service Users within 48 hours either electronically via PharmOutcomes or a hard copy posted.

- All Service Users identified as being high risk will be followed up by the Provider via telephone after 4 weeks to determine whether or not they have made an appointment to see their GP.
- A summary list of all Service Users, who have undertaken the NHS Health Check, is given to GPs on a monthly basis by the Provider.

The NHS Health Check Programme requirement is for 20% of the eligible population to be invited each year over the five year rolling programme with a target of 50% uptake of eligible people.

This service will also contribute to achieving other outcomes in the Public Health Outcomes Framework (listed in Appendix 1).

3. Scope

3.1 Aims and objectives of Service

The aim of this Service is to prevent heart disease, stroke, diabetes and chronic kidney disease by identifying risk factors and managing them appropriately in the eligible population.

The NHS Health Check programme provides a structured approach to cardiovascular risk management for all people aged 40-74 years old, who are not already on any patient risk register (exclusion criteria can be found in section 3.4).

Through the check, their risk of heart disease, stroke, kidney disease and diabetes is assessed through some straightforward tests and standard questions about their lifestyle and family medical history.

Personalised advice and support is then offered to help lower the risk of developing cardiovascular disease.

Those with low or moderate risk are likely to receive advice about changes to their lifestyle, whilst individuals with a higher risk may also be offered medical support (in addition to lifestyle advice) through primary care and onward referral to other specialist support services e.g. smoking cessation and/or weight management.

The scope of the programme is:
- Identification of those people who are eligible (including targeting of hard to reach populations)
- Risk assessment and identification of associated risk factors
- Communication of results and level of risk
- Management of risk (including advice, brief interventions, referral for clinical support, signposting and referral to other services if appropriate)

<u>The core objectives of the Service for the Provider to meet are:</u>

INVITATION & ENGAGEMENT
- Identification of the eligible population

- Invitation of the eligible population
- Use a proactive approach to reach those living in the most deprived quintiles, to address health inequalities, and those potentially at higher risk because of known risk factors such as tobacco, alcohol, obesity.
- To encourage uptake of the Health Check through promotion and marketing.

3.2 Population covered

ELIGIBLE POPULATION

Males and females aged 40 to 74 years
People registered with a GP and living or working in Gateshead. If not registered with a GP but live in the Gateshead area the Provider should advise Service Users on how to register with a local GP.

The NHS Health Check Programme requirement is for 20% of the eligible population to be invited each year over the five year rolling programme with a target of 50% uptake of eligible people.
Providers must ensure they require Service Users to give signed consent to entering into the NHS Health Checks programme. Consent is required:

- to inform the Service User's GP of the test results
- to allow the Provider or the Council to contact the Service User and the Service User's GP for follow up purposes and to discuss the Service User's experiences and outcomes
- to provide Service User anonymised data to the Council for the purposes of Contract monitoring, publication and research.

The Provider must produce and maintain an up-to-date list of all Service Users who they have worked with under this Contract.

3.3 Any acceptance and exclusion criteria
As the programme is a public health programme aimed at preventing disease, people with previously diagnosed vascular disease or meeting the criteria below are excluded from the programme. Those such excluded people should already be being managed and monitored through existing care pathways.

- coronary heart disease
- chronic kidney disease (CKD) which has been classified as stage 3, 4 or 5 within the meaning of the National Institute for Health and Care Excellence (NICE) clinical guideline 182 on Chronic Kidney Disease
- diabetes
- hypertension
- atrial fibrillation
- transient ischaemic attack
- hypercholesterolemia
- heart failure
- peripheral arterial disease
- stroke
- prescribed statins

- people who have previously had an NHS Health Check, or any other check undertaken through the health service in England, and found to have a 20% or higher risk of developing cardiovascular disease over the next ten years

NOTE: Where someone has a CVD risk of 10-19%, they would not be excluded from recall unless they meet one of the other exclusion criteria, e.g., being prescribed a statin.

3.4 MANAGEMENT OF INVITATION PROCESS BY THE COUNCIL

The Council is facing increased budget pressures and is now in the position of needing to continually monitor spend to ensure the budget for this Service is not exceeded. In light of this the Council will:

- Monitor the uptake of health checks by Service Users during quarter 1 and quarter 2. Following receipt of quarter 2 data for uptake rates the Council will project activity data for the remainder of the Contract year.
- Should the projected data show that the Council is not likely to manage spend for the Service within budget, the Council will write to Providers and require this invitation process to be altered to reduce the invitation rate of 20% to a percentage rate that is likely to align engagement to meet the Council's budget.
- Should the Council reduce the invitation rate, an appropriate adjustment of Schedule 2 Performance Indicators will also be made to ensure Providers are not put to a contractual disadvantage.
- Following receipt of quarter 3 uptake data, the Council will again project activity rates for quarter 4.
- Should the projected rates show that the Council, despite reducing the invitation rate, is still not likely to manage spend for the Service within budget, the Council will write to Providers and require this invitation process be altered again to reduce the invitation further in order to meet the Council's budget. However should the projected engagement rate show that the Council is likely to manage spend within budget, the Council will write to Providers to reinstate the status quo (20% invitation rate and current KPIs).

3.5 RISK ASSESSMENT

- face to face assessment of a Service User's cardiovascular risk (which includes heart disease, diabetes, chronic kidney disease and stroke risk)
- Calculation of risk score using QRisk 2 The following tests and measures must be completed during the risk assessment and the results recorded:
- Age
- Gender
- Smoking status
- Family history of coronary heart disease
- Ethnicity
- Body mass index (BMI)
- Cholesterol level Point of Care Testing (POCT)
- Quality Assurance for POCT
- Blood Pressure

- Physical activity level
- Alcohol use assessment
- Diabetes risk assessment (including waist measurement)
- Dementia
- Cardiovascular risk score (QRisk2)
    - A diagram of the overview of the NHS Health Check Programme can be found in the supporting guidance document (Appendix 1)
- For further details on any of these elements, and referral thresholds please see Appendix 1.
- The individual having an NHS Health Check must be told their BMI, cholesterol level, blood pressure, Diabetes Risk and AUDIT score as well as their cardiovascular risk score. In addition, Dementia risk reduction messaging to be included in the NHS Health Check, for everyone eligible, aged 40-74.
- Communication of cardiovascular disease risk to Service Users in a way which is understood. Everyone having the NHS Health Check should be provided with individually tailored advice that will help motivate them and support the necessary lifestyle changes to help them manage their risk.
- The Provider will provide lifestyle advice to ALL Service Users having a Health Check, regardless of their risk score on how to maintain/improve their vascular health, unless deemed clinically inappropriate. Lifestyle advice and support includes providing brief interventions.
- Lifestyle measures that can reduce CVD risk include:
    - Smoking cessation.
    - Weight loss if overweight or obese.
    - Eating a healthy diet.
    - Keeping alcohol consumption within the recommended limits.
    - Being physically active.
- A diagram of the risk assessment and management can be seen below. (Figure 2).

Results (level of risk)

If level of risk is less than 10% provide tailored lifestyle advice based on the assessment results. This may include written information, brief interventions, lifestyle support from the Pharmacy or signposting/referral to other local services for e.g. stop smoking support. Our Gateshead is a community website with information on events, activities, groups in Gateshead https://www.ourgateshead.org/.

It must be made clear both verbally and in writing that service users do not need to seek further follow up from their GP, and that they only need a Health Check once every 5 years.

If level of risk is 10% or greater treatment with statins may be recommended in addition to lifestyle changes. This may include written information, brief interventions, lifestyle support from Pharmacy or referral to other local services for e.g. stop smoking support. If Service User agrees to statins, they will be considered as being managed and will not be eligible for further NHS Health Checks. If the Service User refuses statins, they will be eligible for a NHS Health Check in five years

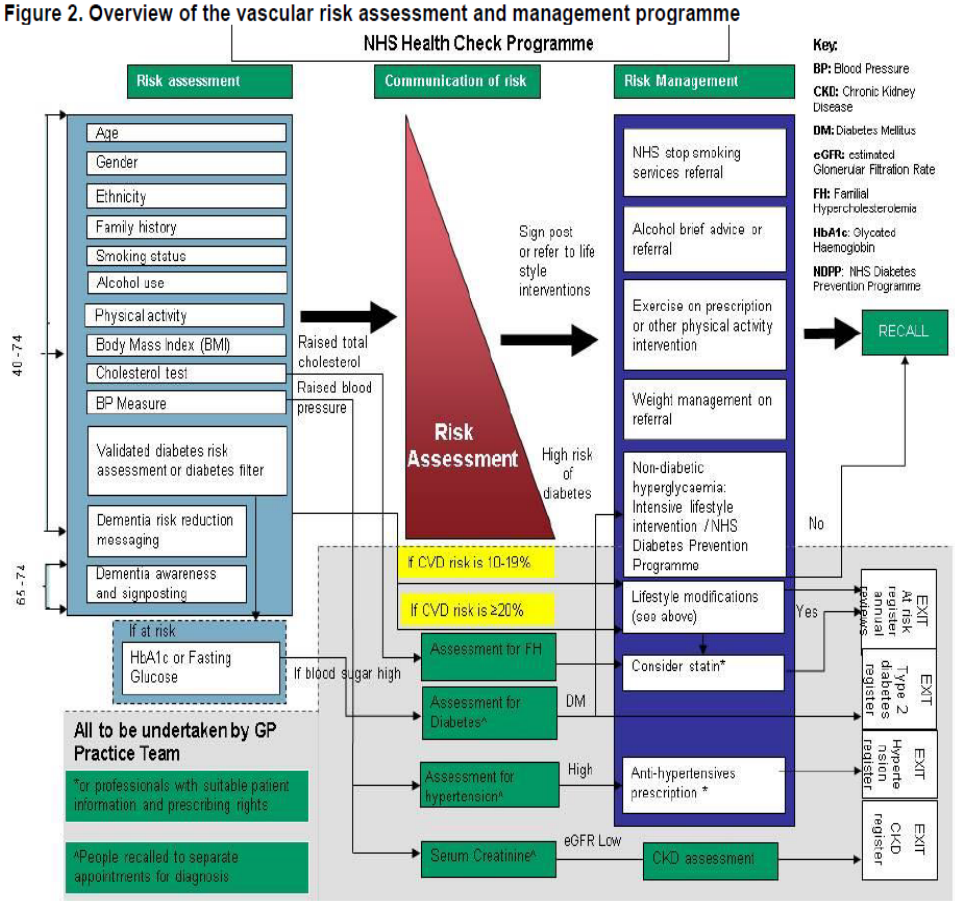
If the Service User needs further follow up from their GP, they should be advised of the relative urgency of this follow-up and this should also be recorded on their Health Check results leaflet.

If level of risk is 20% or greater, the Service User should be transferred to the appropriate treatment pathway in Primary care, in addition to lifestyle advice/support. This may include written information, brief interventions, lifestyle support from Pharmacy or referral to other local services for e.g. stop smoking support.

If the Service User needs further follow up from their GP, they should be advised of the relative urgency of this follow-up and this should also be recorded on their Health Check results leaflet.

NHS Health Check: Best practice guidance

Figure 2. Overview of the vascular risk assessment and management programme



Potential variations for 2022/23
The following changes have been introduced into the new Best Practice Guidance, but the systems/pathways aren't currently in place to allow these changes to be implemented locally and the Council is awaiting further national guidance.

QRISK3
Estimated 10-year risk of developing CVD should be calculated using QRISK. In 2019, the 10-year CVD risk factor calculator QRISK® 2 was replaced by QRISK® 3, which uses a further seven fields of data (diagnosis of chronic kidney disease, a measure of systolic blood pressure variability (standard deviation of repeated measures), migraine, corticosteroids, systemic lupus erythematosus, atypical antipsychotics, severe mental illness, and erectile dysfunction). These additional variables help to enable a more precise identification of people most at risk of heart disease and stroke.

In Pharmacy, if there is no way to automatically pull information on the new variables from a person's medical into the risk calculator, QRISK® 3 may, for the time being, be used with the QRISK® 2 fields only. A score calculated in this way is considered a limited QRISK® 3 score. Therefore, practitioners must explain that the assessment may underestimate a person's risk if they have one of the seven additional clinical variables.

QRisk3 will be introduced as into this Service further guidance becomes available. Providers will be informed in good time and supported to make any necessary amendments

Audit Score - new advice on the clinical management of people with an AUDIT score of 16 or more being referred for an assessment for cirrhosis, via local pathways (see Section 6.7 of Best Practice Guidance)

These potential changes to service delivery will be covered in the annual update training and will be encorporated into the Service Specification in due course via a Contract variation.

3.6 Point of Care Testing
Where Point of Care Testing is utilised the Provider must ensure that they comply with the specific guidance on POCT set out in the NHS Health Check Programme Standards (2020). The use of point of care testing machines (POCT) is recommended as best practice for the Gateshead NHS Health Checks Programme and should be used where appropriate quality assurance mechanisms are in place.

The Provider should ensure that sufficient appointment time is arranged to conduct the full risk assessment, communicate the results in a way the Service User understands and offer ongoing referral to relevant lifestyle support services. National guidance indicates that the full NHS Health Check takes around 20-30 minutes to complete.

Point of Care Testing may be utilised by the Provider when delivering the NHS Health Check to allow the clinician to deliver the full results of the check immediately, without the requirement

for bloods to be sent away for testing and a further contact with the Service User to deliver the results.

The Provider is required to purchase and maintain their POCT equipment for NHS Health Checks. It is the Provider's responsibility to provide all necessary equipment and facilities required to conduct a Health Check. This includes a private area for assessment, height and weight measuring devices, blood pressure monitors, point of care testing equipment, consumables (including suitable storage and disposal facilities e.g. refrigerator and sharps bins). Information on POCT machines is available in Management and use of IVD point of care test devices, MHRA, 2021 Management and use of IVD point of care test devices.pdf (publishing.service.gov.uk), NHS Health Check Best Practice Guidance, 2019 (updated 2020) NHS Health Check - National guidance and B0722-Point-of-Care-Testing-in-Community-Pharmacies-Guide_January-2022.pdf (england.nhs.uk)

The Provider must undertake appropriate mandatory training and annual update training (see Schedule 1). The Provider must ensure compliance with quality control testing as these are crucial to ensure that health care professionals can be confident that the POCT equipment continues to deliver lab- accurate results. The Provider must identify a lead contact for POCT and External Quality Assessment (EQA) and inform the Public Health Programme Lead (Helenbell@gateshead.gov.uk) of both the name of the contact for POCT and the pharmacy's EQA provider. If this named contact changes, the Council must be informed. POCT Providers must keep records to demonstrate compliance with monthly EQA and share results with Council upon request.

Further guidance on POCT equipment can be found in Appendix 1.

3.7 RISK MANAGEMENT

Management of risk factors in line with National Best Practice and NICE guidance including:

- Advice on lifestyle risk factors and signposting to other services as appropriate for all Service Users
- Providing brief lifestyle interventions for e.g. stop smoking brief advice, physical activity brief intervention, alcohol brief intervention.
- Medical management of cardiovascular risk if required. Please refer to diagram above for further tests and exits from the programme (section 3.5).
- To appropriately manage risk, personalised interventions or treatment plans offered for these Service Users in line with clinical guidance.
- To increase awareness of dementia risk reduction messages for everyone eligible aged 40-74.
- To provide advice on maintaining healthy lifestyles for all levels of risk and referral to health improvement services where appropriate. This may include written information, brief interventions, lifestyle support from Pharmacy or referral to other local services for e.g. stop smoking support.
- To collect and record data in the PharmOutcomes system and share results with Primary Care.

3.8 QUALITY ASSURANCE

- It is important to consider how the NHS Health Check tests and measurements are standardised and quality assured.

- Copy of results given to Service User, in an appropriate language and format, using the standardised results report on PharmOutcomes
- Accurate recording and coding of NHS Health Check
- Record on PharmOutcomes all NHSHCs and share results with GP.

Providers using Point of Care Testing equipment for e.g. LDX Cholestech Machine or equivalent, to perform required checks with every use of machine and monthly external quality assurance testing (for e.g. **RIQAS or WEQAS** or equivalent). Monthly EQA data should be shared with the Council on request. The Provider is to deliver requested EQA data to the Council within 10 working days of receipt of such request.

If equipment is not used correctly, there is a risk that incorrect readings are given, affecting the risk score and potentially the clinical management of the individual. Incidents should be reported as soon as possible. Some apparently minor incidents may have greater significance when aggregated with other similar reports. Each POCT location is required to be registered in and participating in an appropriate EQA programme through an accredited (CPA or ISO 17043) provider. Further information quality control for POCT can be found in the NHS Health Check Programme Standards (Standard 5 p18 https://www.healthcheck.nhs.uk/commissioners_and_providers/guidance/national_guidance1/).

QUALITY ASSURANCE (QA) SCHEME FOR POCT

It is essential that Providers are registered with an accredited Quality Assurance scheme (such as RIQAS or WEQAS). It is the Provider's responsibility to make arrangements for an accredited quality assurance scheme. Providers are required to sign-up to and participate in an External Quality Assessment (EQA) scheme such as RIQAS or WEQAS or equivalent. All equipment should be fully functional, accurate and regularly calibrated. POCT equipment should be checked internally either daily, or on those days it is being utilised. It is the Provider's responsibility to do this.

Your local hospital laboratory or other accredited provider can be consulted for advice regarding appropriate quality control process for POCT. In addition local healthcare scientists can offer support to services wishing to set up POCT services (NHSHC National Programme Standards section 5 update).

The monthly Quality Assurance scheme ensures that the cholesterol analysers and the Providers are delivering accurate assessments at all times. Usually for each POCT machine, a monthly sample from the pathology laboratory at the Hospital will be sent to the Provider's named lead. Each month a sample will be sent to each site to run on their POCT equipment and results must be submitted via an online portal. Providers will get an immediate response as to whether they have passed or failed. The Providers will know almost instantaneously how their system is performing. POCT Providers must keep records to demonstrate compliance with monthly EQA and share results with the Council on request. The Provider is to deliver requested EQA data to the Council within 10 working days of receipt of such request.

Documentation relating to the quality assurance processes utilised by the Provider must be made available to the Council on request. Failure to comply with the required QA processes will result in suspension of this Contract, until sufficient evidence of compliance is provided. Participation in a Quality Assurance scheme provides reassurance that Service User results are reliable and accurate. It is important that the Provider submits results for each machine / site on a monthly

basis as this not only guarantees the accuracy of the analyser, but also tests the operator to ensure they are carrying out the correct protocol.

3.9 Interdependencies with other services

The Public Health Trainer (Public Health, the Council) provides training support. For further information, please contact Ian Black on Tel: 0191 433 3563 or lanblack@gateshead.gov.uk. For queries on other areas of Health Checks, please contact Helen Bell, Public Health Programme Lead for NHS health checks. Tel: 0191 433 3628 or Helenbell@gateshead.gov.uk

GP Practices - Data collection for all NHS Health Checks is collected via the GP practice system EMIS. This relies on Service User reports being sent to the practice by the provider and uploaded on to the EMIS system by the GP Practice.

Data from the Provider is to be entered into the PharmOutcomes system using the appropriate module in the system and sent to the GP Practice.
GP Practices will receive the results of NHS Health Checks carried out by the Provider. The Provider must ensure that the results of NHS Health Checks are sent to the Service User's GP Practice within 48hours.The Provider must make arrangements for a paper copy of results to be sent to Practices if an electronic copy cannot be sent via PharmOutcomes.
For individuals eligible for a NHS Health Check but do not wish to have the appointment in the Pharmacy, the Provider should signpost to another NHS Health Check Provider in Primary Care.

Performance Data is provided monthly from PharmOutcomes to the Council.

4. Applicable Service Standards

4.1 Applicable national standards

Best Practice Guidance
NHS Health Check Programme Best Practice Guidance, October 2019 – updated March 2020
https://www.healthcheck.nhs.uk/commissioners-and-providers/national-guidance/
Further guidance can be found in Appendix 1

4.2 Activity planning assumptions

The Provider must reach 120 NHS Health Checks per year, this equates to a minimum of 10 per month

- The Provider is to ensure that it delivers the following when providing the Services:-
- A standardised approach to delivering NHS Health Checks.
- The Provider will be responsible for ensuring that all Staff who undertake NHS Health Checks are fully trained and able to demonstrate and maintain the required competencies. For guidance on competencies the Provider is referred to the NHS Health Check Competency Framework (March 2015) The Providers will also ensure that staff maintain competencies and record evidence of competencies, and supervision is provided as appropriate.
- All Staff involved in delivering NHS Health Checks must have read and understood the Contract Specification for NHS Health Checks and National Best Practice Guidance http://www.healthcheck.nhs.uk/national_guidance/
- To ensure that the health check takes place in a consistent, accurate and safe manner.

- Record all elements of the risk assessment and risk management of NHS Health Checks completed.
- Motivational interviewing techniques should be used to guide, encourage and support behaviour change
- The Provider will carry out NHS Health Checks in accordance with best practice advice provided by the National NHS Health Checks Team http://www.healthcheck.nhs.uk/commissioners_and_providers/guidance/ and the Council's policies and procedures.
- Transfer of data to General Practice within 48hrs via email or post
    - The Provider must transfer Service User identifiable data to the general practice in a secure and safe way in line with Council policy in order that responsibility for the Service User remains with the GP. It is expected that the Provider will adhere to information governance in the delivery of such information by gaining consent from the Service User and ensuring Service User data is sent by first class post within 48 hours. This report should be the standard format from PharmOutcomes which includes the NHS Health Check header. The letter contents must include coding information and full assessment results.
- All Service Users identified as being higher risk must receive a follow up from the Provider via telephone after 4 weeks to determine whether or not they have made an appointment to see their GP.
- Any Service User identified as a smoker will be offered referral to the pharmacy stop smoking service by the Provider.
- The Provider must maintain up to date information about where Service Users are to be signposted to.
- The report sent to the GP by the Provider must highlight where the Service User has been signposted.
- All appropriate recordings and interventions must be accurately recorded on the software by the provider and reported to the service users GP.
- The results of each test/measurement must be explained to the Service User by the Provider and appropriate referral and advice given, and shared with the GP where relevant
- The Provider must utilise a professional and Service User centred approach to maximise the likelihood of a positive and motivational experience for the Service User.
- The Service must be provided within the locality of Gateshead within the opening hours of the Provider. The Service must be delivered from facilities and settings which are suitable for the purpose and support the confidentiality and dignity of the Service User.
- The Provider as a pharmacy is eligible to offer NHS Health Checks and be involved in community outreach work. The Public Health Programme Lead (Helen Bell Tel: 0191 433 3628 or Helenbell@gateshead.gov.uk) must be informed of any planned outreach work.
- NHS Health Checks must be conducted in a venue that offers a private and comfortable environment. Where individual rooms cannot be used then a private space is required such as a portable cubicle or the use of a screened off area. It must allow for the Service User's privacy and dignity to be respected. All community venues used to carry out NHS Health Checks must be appropriate venues for privacy and safety requirements.
- The Provider shall work with the Council to review progress and identify any further training needs.
- Ensure that there are suitable contingency plans in place to cover leave (both anticipated and unanticipated) of any Staff leaving the Provider.
- Notify the Council immediately if the Service is not available due to workforce issues.

- Participate in any Gateshead Council organised audit of service provision or health equity audit on access to and take-up of health checks. Co-operate with any national or Gateshead Council led assessment of Service User experience.
- The Department of Health has set minimum levels for the number of people invited and having a check. These are 20% and 10% respectively of the eligible population. Local results are reported to the national team on a quarterly basis. Results can be accessed via the NHS Health Check website www.healthcheck.nhs.uk and there is a NHS Health Check national interactive data map
- Ensure there are clear documented procedures for infection control, storage and disposal of clinical waste, needle stick injuries/spillage and SUI's reporting
- Work with Gateshead Council Health & Wellbeing Intervention Lead (Provides NHS Health Check Mentoring and Training) as appropriate to support delivery of the NHS Health Check Programme
- The Provider is required to share information to Gateshead Council upon request, on the names of staff delivering NHS health checks in practice, and a named lead contact for NHSHC, and where appropriate a named lead contact for POCT.

5. Location of Provider Premises

See Contract Particulars

SCHEDULE 1

CONDITIONS PRECEDENT

1. **General Pharmaceutical Council**
If so requested, provide the Council the General Pharmaceutical Council Registration Number for the pharmacy premises along with details of a Pharmacy Superintendent and their GPhC Number.

2. Insurance

If so requested, provide the Council with a copy of the insurance policies to illustrate that the Required Insurances are in place;

3. Training & Qualifications

All providers delivering NHS Health Checks must:

- Identify the Pharmacist/Pharmacy Manager as the person who has overall responsibility for ensuring that the service is delivered in accordance with this specification.
- Be able to demonstrate that the pharmacy staff who wish to participate in the delivery of this service achieve and maintain appropriate clinical competence and that they have undertaken suitable education and training. The competency framework and learner and assessor workbooks can be used to record evidence and can be accessed here http://www.healthcheck.nhs.uk/commissioners_and_providers/training/competence_framework_supporting_workbooks/
- Be familiar with the NHS Health Check Best Practice Guidance (Oct 2019) https://www.healthcheck.nhs.uk/commissioners-and-providers/national-guidance/
- Undertake the mandatory training prior to delivering NHS Health Checks and undertake an annual update. It is the provider's responsibility to arrange POCT training with their equipment/consumables provider, and to be trained to carry out the Quality Assurance checks.
- All Staff delivering NHS Health Checks must have received training endorsed by the Council to do so. Please contact Ian Black (IanBlack@gateshead.gov.uk) for further information or book a training session via PHTraining@gateshead.gov.uk

The national NHS Health Check team has developed several videos to help train people who carry out NHS Health Checks http://www.healthcheck.nhs.uk/commissioners_and_providers/training/training_videos1/

On the NHS Health Check Website there are also some e-learning packages http://www.healthcheck.nhs.uk/commissioners_and_providers/training/elearning_resources1/

Providers should access the Web based NHS Health Check dementia training tool (dementia awareness training). It is aimed at those individuals providing the NHS Health Check and includes a self-assessment section which will then

provide a certificate of completion. The NHS Health Check dementia leaflet has been developed to support the dementia information and should be given to those aged 65-74 years of age during their appointment. These leaflets can be downloaded here NHS Health Check - Leaflets or are available to order free of charge and in a variety of formats and languages through the UK Health Security Agency Health Publications webpage Search Publications - Health Publications

4. Reporting

All NHS Health Checks must be recorded onto the PharmOutcomes system using the appropriate module in the system. The Provider will report health check activity data on PharmOutcomes according to the Council's requirements on a monthly basis.

The Provider must produce and maintain an up-to-date list of all Service Users who they have worked with under this Contract.

The Provider must transfer Service User identifiable data to the general practice in a secure and safe way in line with Council policy in order that responsibility for the Service User remains with the GP. It is expected that the Provider will adhere to information governance in the delivery of such information by gaining consent from the Service User and ensuring Service User data is either sent electronically via PharmOutcomes or sent by first class post within 48 hours. This report should be the standard format from PharmOutcomes which includes the NHS Health Check header. The letter contents must include coding information and full assessment results.

5. Immunisation and equipment

Hepatitis B vaccination is recommended for the following groups who are considered at increased risk:

● ***healthcare workers in the UK and overseas (including students and trainees):*** all healthcare workers who may have direct contact with patients' blood, blood-stained body fluids or tissues, require vaccination. This includes any staff who are at risk of injury from blood-contaminated sharp instruments, or of being deliberately injured or bitten by patients

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/628602/Greenbook_chapter__18.pdf

The Provider will ensure that Staff are given appropriate equipment and appropriate safety clothing.

Hand washing facilities with running hot water in the consultation room or close by. In the absence of a sink then antibacterial hand wipes must be provided and used in line with Council policy.

6. Patient Group Directive

Not applicable

SCHEDULE 2
PERFORMANCE INDICATORS

Performance Indicators	Threshold	Method of Measurement	Consequence of breach
The NHS Health Checks Community Pharmacy Programme will be monitored monthly. An indicative target has been set by the Council of a minimum of 120 NHS Health Checks per annum (30 quarterly) by the Provider.	10 per month	Analysis of PharmOutcomes data monthly	Appropriate action under Clause 24 of the Terms and Conditions (Defaults and Suspension)
The Provider will report activity data on PharmOutcomes according to the Council's requirements.	Data reported monthly	Reported to the Council monthly – the Council has access to PharmOutcomes	Appropriate action under Clause 24 of the Terms and Conditions (Defaults and Suspension)
The Provider must ensure transfer of data to General Practice	Every NHS Health Check	Monthly PharmOutcomes data report and Quarterly data extraction from GP Practice.	Appropriate action under Clause 24 of the Terms and Conditions (Defaults and Suspension)
Providers will record all elements of the NHS Health Check on the PharmOutcomes system, including lifestyle advice and referrals.	100% compliance	Quarterly monitoring	Appropriate action under Clause 24 of the Terms and Conditions (Defaults and Suspension)

Providers can demonstrate that the CVD risk is communicated and recorded for all HC's	100% compliance	Quarterly monitoring	Appropriate action under Clause 24 of the Terms and Conditions (Defaults and Suspension)
The Provider ensures that staff involved in the provision of NHS Health Checks have undertaken the training required.	100% compliance	Regular monitoring of training attendance.	Appropriate action under Clause 24 of the Terms and Conditions (Defaults and Suspension)
POCT Providers must demonstrate compliance with monthly EQA and share results with Council upon request	100% compliance (failure to provide EQA data within 10 working days of Council request, or provision of EQA data that demonstrates failure to comply with EQA requirement, upon any Council request is deemed a breach of the Performance Indicator)	Regular Council requests for demonstration of compliance by means of submission of EQA data and shared results. The Provider is to deliver requested EQA data to the Council within 10 working days of receipt of such request.	Appropriate action under Clause 24 of the Terms and Conditions (Defaults and Suspension)

A quality audit assessment can be arranged at any point within the Term of the Contract. To minimise the administrative burden, the Council would accept from Providers (where applicable), existing quality audit information generated for the purposes of other principal stakeholders, for example NHS England (NHSE), Care Quality Commission (CQC).

The Council will endeavour to give the Provider 28 days' notice that it is carrying out the assessment, however if concerns or issues are raised regarding the Service, the Council can carry an unplanned assessment without any notice.

Quarterly feedback on Provider performance is emailed by the Council to the Provider at the end of each quarter.

Should the Council, in accordance with clause 3.4 of the Specification, manage the invitation process in quarter 3 and 4, these Performance Indicators will be reflected accordingly to ensure the Provider is not put to any contractual disadvantage.

SCHEDULE 3

PRICING

In consideration of the Provider delivering the Service the Council will pay the Provider the following Price

Element to be Delivered	**Amount**	**Conditions**
NHS Health Check	£40 per NHS Health Check completed	Application of the eligibility criteria A completed NHS Health Check comprises invitation/s, full Health Check assessment, communication of risk, lifestyle advice/referral and risk management Evidence of completed monthly QA checks submitted to Council on request. NHS Health Checks must be recorded on PharmOutcomes

The Provider shall submit to the Council on a monthly basis via the PharmOutcomes system. The Council shall pay the Provider the Price following verification of the claim form, within 30 days of submission of the claim form.

The Price shall remain as set out in this Schedule during the financial year 2022/2023.

In the event that the Contract is extended in accordance with Clause 2.4 the Price shall continue at the same rate, unless a variation is agreed with Council. Where appropriate, the Council shall pay the Price on a pro-rata basis in respect of any extension period.

SCHEDULE 4

DATA SHARING FOR HEALTH CHECKS SERVICE

DEFINITIONS

Agreed Purposes: The performance by each party of its obligations under this Contract and in order to deliver the Service under the provisions of the National Health Service Act 2006 with the Localism Act 2011 providing the incidental powers to share data in order to allow for payment to be made for the provision of the Service.

Controller, data controller, processor, data processor, data subject, personal data, processing and appropriate technical and organisational measures: as set out in the Data Protection Legislation in force at the time.

Data Protection Legislation: (i) the Data Protection Act 1998, until the effective date of its repeal (ii) the General Data Protection Regulation (*(EU) 2016/679*) **(GDPR)** and any national implementing laws, regulations and secondary legislation, for so long as the GDPR is effective in the UK, and (iii) any successor legislation to the Data Protection Act 1998 and the GDPR, in particular the Data Protection Bill 2017-2019, once it becomes law.

Permitted Recipients: The parties to this agreement, the employees of each party, Service User's GP practice and the PharmOutcomes system.

Shared Personal Data: the personal data to be shared between the parties under clause 1.1 of this agreement. Shared Personal Data shall be confined to the following categories of information relevant to the following categories of data subject:

a) Unique identifier number of Service User;

b) Age of Service User;

c) Postcode district of Service User;

d) Whether in a lower super output area;

e) Ethnicity of Service User;

f) Gender of Service User;

g) Service User's GP practice;

h) Where and when the Service took place;

i) Whether the Service User has received the Service in the last five years;

j) Medical checklist pass/fail for Service User eligibility;

k) Medication pass/fail for Service User eligibility; and

l) BMI range of Service User, pulse palpitation of Service User taken, smoking status recorded, whether alcohol assessment undertaken, family history checked Risk 2 Score of Service User, advice and referral information given to Service User.

1. DATA PROTECTION

1.1 **Shared Personal Data.** This clause sets out the framework for the sharing of personal data between the parties as data controllers. Each party acknowledges that one party (the Data Discloser) will regularly disclose to the other party (the Data Recipient) Shared Personal Data collected by the Data Discloser for the Agreed Purposes and shared via the PharmOutcomes system.

1.2 **Effect of non-compliance with Data Protection Legislation.** Each party shall comply with all the obligations imposed on a controller under the Data Protection Legislation, and any material breach of the Data Protection Legislation by one party shall, if not remedied within 30 days of written notice from the other party, give grounds to the other party to terminate this agreement with immediate effect.

1.3 **Particular obligations relating to data sharing.** Each party shall:

(a) ensure that it has all necessary notices and consents in place to enable lawful transfer of the Shared Personal Data to the Permitted Recipients for the Agreed Purposes;

(b) give full information to any data subject whose personal data may be processed under this agreement of the nature such processing. This includes giving notice that, on the termination of this agreement, personal data relating to them may be retained by or, as the case may be, transferred to one or more of the Permitted Recipients, their successors and assignees;

(c) process the Shared Personal Data only for the Agreed Purposes;

(d) not disclose or allow access to the Shared Personal Data to anyone other than the Permitted Recipients;

(e) ensure that all Permitted Recipients are subject to written contractual obligations concerning the Shared Personal Data (including obligations of confidentiality) which are no less onerous than those imposed by this agreement;

(f) ensure that it has in place appropriate technical and organisational measures, reviewed and approved by the other party, to protect against unauthorised or unlawful processing of personal data and against accidental loss or destruction of, or damage to, personal data.

(g) not transfer any personal data received from the Data Discloser outside the EEA unless the transferor:

(h) complies with the provisions of Articles 26 of the GDPR (in the event the third party is a joint controller); and

(i) ensures that (i) the transfer is to a country approved by the European Commission as providing adequate protection pursuant to Article 45 GDPR; (ii) there are appropriate safeguards in place pursuant to Article 46 GDPR; or (iii) one of the derogations for specific situations in Article 49 GDPR applies to the transfer.

1.4 **Mutual assistance.** Each party shall assist the other in complying with all applicable requirements of the Data Protection Legislation. In particular, each party shall:

(a) consult with the other party about any notices given to data subjects in relation to the Shared Personal Data;

(b) promptly inform the other party about the receipt of any data subject access request;

(c) provide the other party with reasonable assistance in complying with any data subject access request;

(d) not disclose or release any Shared Personal Data in response to a data subject access request without first consulting the other party wherever possible;

(e) assist the other party, at the cost of the other party, in responding to any request from a data subject and in ensuring compliance with its obligations under the Data Protection Legislation with respect to security, breach notifications, impact assessments and consultations with supervisory authorities or regulators;

(f) notify the other party without undue delay on becoming aware of any breach of the Data Protection Legislation;

(g) at the written direction of the Data Discloser, delete or return and delete Shared Personal Data and copies thereof to the Data Discloser on termination of this agreement unless required by law to store the personal data;

(h) use compatible technology for the processing of Shared Personal Data to ensure that there is no lack of accuracy resulting from personal data transfers;

(i) maintain complete and accurate records and information to demonstrate its compliance with this Schedule 4 and allow for audits by the other party or the other party's designated auditor; and

(j) provide the other party with contact details of at least one employee as point of contact and responsible manager for all issues arising out of the Data Protection Legislation, including the joint training of relevant staff, the procedures to be followed in the event of a data

security breach, and the regular review of the parties' compliance with the Data Protection Legislation.

1.5 **Indemnity.** Each party shall indemnify the other against all liabilities, costs, expenses, damages and losses (including but not limited to any direct, indirect or consequential losses, loss of profit, loss of reputation and all interest, penalties and legal costs (calculated on a full indemnity basis) and all other reasonable professional costs and expenses) suffered or incurred by the indemnified party arising out of or in connection with the breach of the Data Protection Legislation by the indemnifying party, its employees or agents, provided that the indemnified party gives to the indemnifier prompt notice of such claim, full information about the circumstances giving rise to it, reasonable assistance in dealing with the claim and sole authority to manage, defend and/or settle it. The liability of the indemnifying party under this clause shall be subject to the limits set out in 22 of the Terms and Conditions of this Contract.

APPENDIX 1
SUPPORTING GUIDANCE FOR THE DELIVERY OF NHS HEALTH CHECKS

National/local context and evidence base
Reducing avoidable premature mortality is a government priority. For males 28% of the gap in life expectancy between the most and least deprived fifth of areas in England is due to excess deaths from circulatory diseases, and for females this figure is 24%. If diabetes and urinary conditions are added to circulatory diseases, then excess deaths from these conditions together contribute to 31% of the gap between the most and least deprived fifth in England for males and 28% for females. Additionally, the cost of social and health care from the rise in levels of obesity, type 2 diabetes and dementia makes the prevention and risk reduction of these conditions key drivers of the programme.

CVD prevention, early detection and management
The Department of Health estimated that the programme could prevent 1,600 heart attacks and strokes, at least 650 premature deaths, and identify over 4,000 new cases of diabetes each year. At least 20,000 cases of diabetes or kidney disease could be detected earlier, allowing individuals to be better managed to improve their quality of life. The estimated cost per quality adjusted life year (QALY) is approximately £3,000. The evidence also shows that the programme isn't just reaching the worried well, there is equitable access among groups with the greatest CVD risk. The evidence reviews for the programme can be found here http://www.healthcheck.nhs.uk/commissioners_and_providers/evidence/

Since 2013, the programme has also aimed to reduce levels of alcohol related harm, and to raise awareness of the signs of dementia and signpost people for help. Everyone attending a NHS Health Check will have their alcohol consumption risk assessed. From 2018 Dementia risk reduction messaging is to be included in the NHS Health Check, for everyone eligible, aged 40-74. Please refer to NHS Health Check Programme Best Practice Guidance (Oct 2019).

Health Inequalities
One of the programme's objectives is to reduce health inequalities. Local authorities may tailor the delivery of the programme in a number of ways to achieve this. Although local authorities have a duty to offer the NHS Health Check to all eligible people, PHE supports approaches that prioritise invitations to those with the greatest health risk. For example, by prioritising invitations to people with an estimated ten-year CVD risk score greater than 10% or those living in their most deprived areas. The persistent inequality between the least and most deprived areas in England is a further reason for the pressing need to improve the scale and reach of preventive services. In order for NHS Health Checks to be effective at reducing health inequality, it is important to have high and equitable uptake in high risk populations, as risk factors of tobacco use, high blood pressure, excess alcohol consumption, high cholesterol and being overweight are key reasons for inequalities in health and life expectancy.

The NHS Health Check programme can reduce health inequalities by:

- increasing healthy life expectancy by through lifestyle and clinical management of risk factors that cause preventable disease and disability
- reducing differences in healthy life expectancy and overall life expectancy within and between communities at ward level within local authorities
- reducing premature preventable death by assessing the risk of developing a condition and providing necessary treatment if the condition presents itself

An effective way to find people with undiagnosed heart disease is through NHS Health Checks.

The Provider is to adopt a motivational interviewing technique in delivering NHS Health Checks. Staff who deliver NHS Health Checks must be trained appropriately for the element of NHS Health Checks they are delivering e.g. collecting data (height and weight), using equipment for point of care testing and/or undertaking a NHS Health Check assessment and informing Service Users of their level of risk. The provider is required to offer lifestyle advice and brief interventions where appropriate. for e.g. stop smoking brief advice, physical activity brief intervention, alcohol brief intervention. Training requirements are detailed in Schedule 1 - conditions precedent section of this Specification.

The Gateshead NHS Health Checks programme appears to be finding people at high risk of CVD. For every 10 health checks, 2 new high risk individuals are identified and 1 person with previously unrecognised hypertension (Lambert, M (2015) Assessing potential local routine monitoring indicators of reach for the NHS health checks programme. Public Health. journal homepage: www.elsevier.com/puhe)

Further information on the Public Health Outcomes Framework can be found here: Public Health Outcomes Framework - OHID (phe.org.uk)

Further information on the health issues for Gateshead can be found here: Gateshead Health and Wellbeing Board and Joint Strategic Needs Assessment

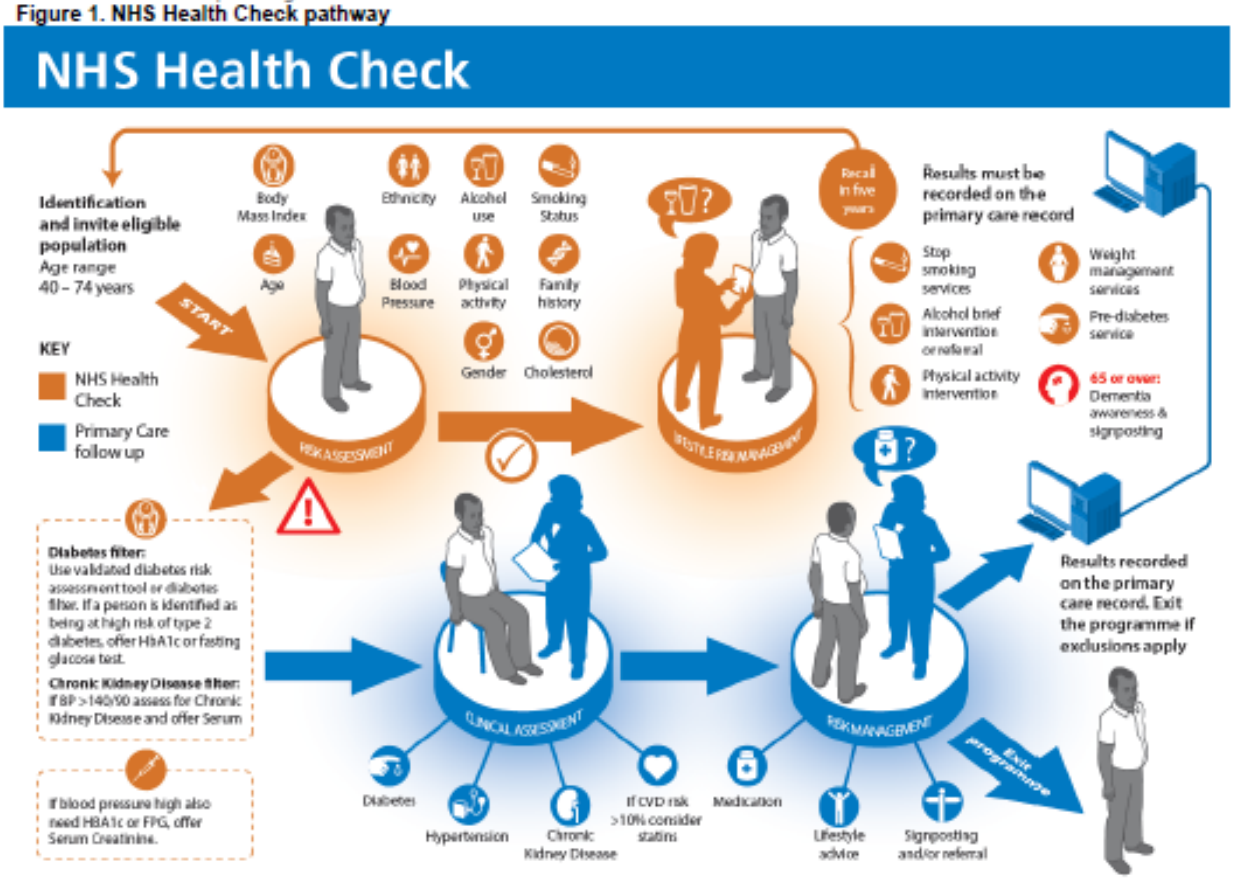
The service is to be provided in a manner that will contribute to achievement of the following outcomes from the Public Health Outcomes Framework:

- Cumulative percentage of the eligible population aged 40-74 offered a NHS Health Check in the five year period 2013/14 - 2017/18 (2.22iii).
- Cumulative percentage of eligible population aged 40-74 offered a NHS Health Check who received a NHS Health Check in the five year period 2013/14 - 2017/18 (2.22iv).
- Cumulative percentage of eligible population aged 40-74 who received a NHS Health Check in the five year period 2013/14 - 2017/18 (2.22v)
- Mortality rate from causes considered preventable (4.03)
- Under 75 mortality rate from all cardiovascular diseases (4.04i)
- Under 75 mortality rate from all cardiovascular diseases considered preventable (4.04ii)
- Excess weight in adults (2.12)
- Percentage of physically active adults (2.13i)
- Prevalence of smoking among persons aged 18 years and over (2.14)

- Recorded Diabetes (2.17)
- Alcohol-related hospital admissions (2.18)
- Estimated diagnosis rate for people with dementia (4.16)
- Overarching indicators for life expectancy and inequality

Service description/pathway
Below is a diagram of the National NHS Health Check Programme Pathway

NHS Health Check: Best practice guidance
Figure 1. NHS Health Check pathway



IDENTIFICATION AND INVITATION OF ELIGIBLE POPULATION
Providers should consider the communication requirements of their patients when choosing an invitation method/literature e.g. easy read, braille, language etc. The invitation could be in the form of a letter, telephone call, text message or other communication as preferred by the Provider and Service User.

Pilots led by Public Health England have found that sending text prompts and reminders in addition to a shortened letter increased NHS Health Check uptake by approximately 12% compared with sending the longer standard letter alone. Sending the shortened letter alone increased uptake by approximately 5% compared with sending the longer older letter format.

An information leaflet about the NHS Health Check is available here:
http://www.healthcheck.nhs.uk/commissioners_and_providers/marketing/leaflets/
The information leaflet, as recommended by the Department of Health is also available in Braille, other languages, large print and audio versions. Paper copies are

available to order free of charge and in a variety of formats and languages through the UK Health Security Agency Health Publications webpage Search Publications - Health Publications. The Provider can decide on the optimal call and recall strategy. The invite shall be recorded on the Providers clinical system to enable an accurate call/recall system to be maintained.

Texting prompts and reminders - for Providers with texting facilities who would like to encourage more Service Users to access their Health Check we recommend using the prompt and reminder texts in addition to the letter. Suggested text could include:

- Prompt (1 week prior to letter invite) - <Practicename>: Dear <firstname2>, your NHS Health Check is due at your GP practice. We will post you a letter soon with info about how to book your apt
- Reminder (1 week after letter) <Practicename>: Dear <firstname2>, Your GP recently sent you a letter inviting you to attend your NHS Health Check. Call xxxxxxxxx to book an appt. Eligible patients should be invited as above and those who do not respond should be sent at least one reminder, this can be verbally, by telephone, text or letter. Frequent reminders may prompt patients to access their Health Check.

Service Users excluded should be considered eligible and invited again five years later.

Health inequalities are the unfair and avoidable differences in people's health across social groups and between different population groups. Health inequalities can result in people who are worst off experiencing poorer health and shorter lives. CVD is one of the conditions most strongly associated with health inequalities, with death from CVD three times higher among people in the most deprived communities compared to those that in the most affluent. CVD risk factors tend to cluster together, which has a disproportionate effect on people who are disadvantaged, further increasing inequalities. Tackling these risk factors will also help prevent other major causes of death and illness, such as type 2 diabetes and many cancers. Public Health England supports approaches that prioritise invitations to those with the greatest health risk. This could include, for example, prioritising invitations to people with an estimated 10 year CVD risk score greater than 10% or those living in the most deprived areas.

Providers could use a systematic approach to identify those within the eligible population most likely to be at higher risk and living in the most deprived areas. The Provider could invite those living in areas of Gateshead with the most deprivation as a priority, and/or with known risk taking behaviour as a priority.
A map showing Gateshead's Lower Super Output Areas (LSOA) by deprivation can be found here: https://www.gatesheadjsna.org.uk/article/6135/Headline-data

Promotion and Marketing
The Provider is required to promote the uptake of NHS Health Checks and to promote NHS Health Check campaigns.
The NHS Health Check http://www.healthcheck.nhs.uk/ provides up-to-date NHS data, syndicated content for websites, toolkits and branded materials to help with promotion and marketing. Materials can be downloaded for print. You will need to register for full access.
There is a factsheet with Top tips to increasing the uptake of NHS Health Checks

(August 2016)
http://www.healthcheck.nhs.uk/commissioners_and_providers/guidance/national_guidance1/

The NHS Health Check Leaflet is available here NHS Health Check - Leaflets or are available to order free of charge and in a variety of formats and languages through the UK Health Security Agency Health Publications webpage Search Publications - Health Publications The leaflet is available in a range of different languages and accessible formats.
(For information - the website will only let you order 1 copy without registering, once registered you can order more copies.) Maximum limits apply.

The Dementia Health Check leaflet can also be ordered via the via the link above.

The NHS Choices website provides public facing information on what to expect from an NHS Health Check and what to do after having a check. It also includes a service directory that provides information on where individuals can get a check in their area. A heart age calculator is also available on NHS Choices and, where appropriate, will prompt users to have an NHS Health Check.

All NHS Health Check content (including videos, links and apps) on NHS Choices is available to stream onto any website, for free, providing an easy way to keep public information on the programme up to date on your own website. Visit the NHS Health Check website to find out more or complete the registration form and a member of the NHS Choices team will contact you to talk through the process.

The One You website provides public facing information on lifestyle choices and how they can influence disease prevention in later life. NHS Health Check is a part of the One You campaign, under the 'Checking' section on the One You website, which provides the public with information on the NHS Health Check and links directly to the materials on NHS choices mentioned in the section above.

Social marketing Our Gateshead has information on NHS Health Check Providers and where to get an NHSHC NHS Health Checks Gateshead | OurGateshead
One You Gateshead also has information on NHSHC's (Facebook www.facebook.com/OneYouGateshead or Twitter www.twitter.com/OneYouGateshead)

Our Gateshead has details of services, groups, events in Gateshead
www.ourgateshead.org/oneyou

NHS HEALTH CHECK RISK ASSESSMENT
For further guidance please refer to Chapter 4 The Risk Assessment of the NHS Best Practice Guidance
Everyone receiving a NHS Health Check is to have a risk assessment from the Provider which will look at individual risk factors, as well as their risk of having, or developing, vascular disease in the next ten years. During the assessment, the Provider is to ensure that the specific tests and measures listed below are completed during the risk assessment and that the results are recorded:

- Age

- Gender
- Smoking status
- Family history of coronary heart disease
- Ethnicity
- Body Mass Index (BMI)
- Cholesterol
  Point of care testing or NON POCT testing
  Quality Assurance for POCT
- Blood Pressure
- Physical Activity Level
- Alcohol Use Assessment
- Diabetes risk assessment (including waist measurement)
- Dementia
- Cardiovascular risk score (QRisk2)

- **AGE**
  Data required: age recorded in years.
  Thresholds: the age of the Service User should be 40-74 years (inclusive).

- **GENDER**
  Data required: the gender should be recorded as reported by the Service User. If the Service User discloses gender reassignment, they should be provided with CVD risk calculations based on both genders and advised to discuss with their GP which calculation is most appropriate for them as an Service User.

- **SMOKING STATUS**
  Data required: non-smoker, ex-smoker, light smoker (fewer than 10 a day), moderate smoker (11-19 a day), heavy smoker (≥ 20 a day).
  It is important to use every opportunity to systematically identify people who smoke and deliver very brief advice (VBA) and follow up, where appropriate, with a referral into effective support. This very brief advice consists of three steps:
  • ASK – establish and record smoking status
  • ADVISE – advise that the best way to stop is with a combination of pharmacotherapy and support
  • ACT – offer a referral to a specialist service

  A Service User who is a smoker who wants to stop, should be offered the support of a local stop smoking service.

- **FAMILY HISTORY OF CORONARY HEART DISEASE**
  Data required: information on family history of coronary heart disease in first-degree relative under 60 years.
  Key points: first-degree relative means father, mother, brother or sister.

- **ETHNICITY**
  Data required: self-assigned ethnicity using one of the following categories: white/not recorded, Indian, Pakistani, Bangladeshi, other Asian, black African, black Caribbean, Chinese, other including mixed.

Key points: ethnicity is needed for the diabetes risk assessment. Ethnicity should be recorded using the Office for National Statistics 2001 census codes.

- **BODY MASS INDEX (BMI)**

  Data required: BMI is required for the CVD risk calculation.
  Data required: BMI is calculated from the weight divided by the height squared of the Service User.
  Key points: if the Service User cannot have their height and/or weight measured, including amputees, their waist circumference, in supine position where possible, can be used to assess whether they are overweight or obese, and their risk of developing diabetes. The thresholds for waist circumference are set out in the NICE obesity clinical guidelines. The QRISK® 2 calculation will default to population averages where information is not added, so it will estimate BMI based on the age and gender entered into it.
  Related stages of the check: BMI is required for the CVD risk calculation. It is also required for the validated diabetes risk assessment tool to identify Service Users at risk of type 2 diabetes.

  Note: if the Service User cannot have their height and or weight measured, the Service User's estimate of their own height and weight can be used as approximations but these are prone to error. Arm span can also be used as an approximation for height.

  Managing weight in individuals who are overweight or obese is complex. Where a Service User's weight status and/or their waist circumference is a key risk factor, advice or onward referral should be provided in line with the NICE clinical guidelines CG189 Obesity: identification, assessment and management. Where the Service User's weight status is not a risk factor, it is still an opportunity to reinforce the benefits of healthy eating and being physically active.
  You may find it helpful to follow the steps outlined in Public Health England's 'Let's Talk About Weight – a step by step guide to brief interventions with adults for health and care professionals'.

  Service Users can be directed to information on the importance of a balanced diet, shown in the Eatwell Guide (The Eatwell Guide Department of Health Feb 2017 https://www.gov.uk/government/publications/the-eatwell-guide)
  - eat at least 5 portions of a variety of fruit and vegetables every day
  - base meals on potatoes, bread, rice, pasta or other starchy carbohydrates; choosing wholegrain versions where possible
  - have some dairy or dairy alternatives (such as soya drinks); choosing lower-fat and lower-sugar options
  - eat some beans, pulses, fish, eggs, meat and other proteins (including 2 portions of fish every week, one of which should be oily)
  - choose unsaturated oils and spreads and eat in small amounts
  - drink 6-8 cups/glasses of fluid a day
  - if consuming foods and drinks high fat, salt, or sugar have these less often and in small amounts

In addition, the Service User's alcohol intake could be considered as part of any discussion about energy intake, and the opportunity used to highlight links between alcohol intake and obesity with liver disease.

- **CHOLESTEROL LEVEL - Total cholesterol/HDL Ratio**

  Providers may undertake the NHS Health Check utilising Point of Care Testing (POCT) or use local laboratory services (non POCT). Further information on this is below.

  Data required: cholesterol must be measured as the ratio of total serum cholesterol to high density lipoprotein cholesterol.

  Key points: - a random cholesterol test should be used for this assessment. A fasting sample is not required.

  - cholesterol is a major modifiable risk factor of vascular disease, and can be reduced by dietary change and physical activity, but medicines may also be required depending on the degree of elevated risk.

New advice (from Best Practice Guidance, October 2019) – where a Service User's cholesterol level is found to be above 7.5mmol/l and/or personal/family history refer to GP for consideration of familial hypercholesterolaemia

For POCT the Provider will require the following equipment:

- Cardiovascular Equipment
  - Cholesterol Analyser - Further details on POCT machines are available in Management and use of IVD point of care test devices, MHRA, 2021 Management_and_use_of_IVD_point_of_care_test_devices.pdf (publishing.service.gov.uk) and NHS Health Check Best Practice Guidance, 2019 (updated 2020) NHS Health Check - National guidance
- External Accredited Quality Assurance Scheme such as Bolton Quality Assurance Scheme or equivalent
- TC/HDL Cholesterol Cassettes or equivalent required for analyser
- Heparinised glass tubes and plungers 40ul
- Unistik 3 Lancets
- Swabs, disposable gloves, plasters
- AA Approved BP Unit, UA 767
- Large Blood Pressure Cuff
- Seca 761 analogue scales
- Height Meter
- Tape measure (for waist measurement)
- The Provider is responsible for the safe disposal of all medical waste, sharps and other refuse generated by the service in accordance with the relevant Health and Safety Regulations.
- It is the Provider's responsibility to make arrangements for ordering consumables.
- The Provider is expected to adhere to Medicines and Healthcare Regulatory Agency (MHRA) advice on selection of appropriate equipment, training in its use and ongoing management, troubleshooting, and quality assurance processes that ensure the accuracy and ability to reproduce results.

- The Provider will report any adverse incidents involving medical equipment to the relevant manufacturer as well as the Medicines and Healthcare products Regulatory Agency (MHRA), follow the ESCC Incident Reporting Policy and process, and manage in accordance with providers' governance arrangements and Council requirements.
- An adverse incident is an event that causes, or has the potential to cause, unexpected or unwanted effects involving the accuracy and/or safety of device users (including Service Users) or other persons.
- Providers will ensure that an appropriate internal quality control (IQC) process is in place. Providers should note that NHS Programme Standards indicate that an appropriate internal quality control (IQC) process for POCT should be delivered in accordance with the MHRA guidelines on POCT, 'Management and use of IVD point of care test (POCT) devices. Device bulletin 2010 (02) February 2010'. This should take the form of at least a daily "go/no go" control sample (use of a liquid sample) on days when the instrument is in use. This may require other procedures e.g. optical check to be performed in addition to the use of a liquid control sample.
  For additional information see:
  - NHS Health Check programme standards: a framework for quality improvement. Public Health England. February, 2014.
  - Management and use of IVD point of care test devices, MHRA, 2021 Management_and_use_of_IVD_point_of_care_test_devices.pdf (publishing.service.gov.uk)
  - NHS Health Check Best Practice Guidance, 2019 (updated 2020 NHS Health Check - National guidance

- **BLOOD PRESSURE MEASUREMENT**
  Both systolic (SBP) and diastolic blood pressure (DBP) are required for the diabetes risk score and for assessment for chronic kidney disease and hypertension within primary care.

  - **Irregular Pulse**
    As set out in NICE clinical guideline 127 (2011) practitioners should perform a pulse rhythm check prior to taking blood pressure to detect any pulse irregularities that could affect the reading from an automated device. Service Users who are found to have an irregular pulse rhythm should be referred to the GP for further investigation.
    Key points: checking the pulse rhythm

    NICE Hypertension clinical guideline 127 (2011) recommends that practitioners should perform a pulse rhythm check prior to taking blood pressure to detect any pulse irregularities. Irregularities can lead to inaccurate blood pressure readings when an automated device is used. Service Users who are found to have an irregular pulse rhythm should be referred to the GP for further investigation of atrial fibrillation.

    If the Service User has a blood pressure at, or above, 140/90mmHg, or where the SBP or DBP exceeds 140mmHg or 90mmHg respectively, the Service User requires:

- **An assessment for hypertension**
  Where a diagnosis of hypertension is confirmed by a clinician, the Service User should be added to the hypertension register and treated in line with NICE guidelines. Once diagnosed with hypertension, Service Users should not be recalled as part of the NHS Health Check programme.
  When blood pressure is found to be high, discussions about possible hypertension diagnosis and management may raise questions about the relationship between lifestyle and blood pressure management. Such discussion will normally take place as part of the further hypertension assessment or once a Service User is placed on the hypertension register. It will however be useful for practitioners to be aware of the lifestyle interventions recommended in the NICE guideline on hypertension:
  - ask people about their diet and exercise patterns, and offer guidance and written or audio-visual materials to promote lifestyle changes
  - ask people about their alcohol consumption and encourage them to cut down if they drink excessively
  - discourage excessive consumption of coffee and other caffeine-rich products
  - encourage people to keep their salt intake low or substitute sodium salt
  - offer advice to people who smoke and help to stop smoking
  - tell people about local initiatives (for example, run by healthcare teams or patient organisations) that provide support and promote lifestyle change
  - do not offer calcium, magnesium or potassium supplements as a method of reducing blood pressure
  - relaxation therapies can reduce blood pressure and people may wish to try them. However, it is not recommended that primary care teams provide them routinely

- **An assessment for CKD**
  The results of a serum creatinine test should be used to calculate the estimated glomerular filtration rate (eGFR) in order to assess the level of kidney function, and recorded on the individual's patient record.
  Threshold: eGFR<60ml/min/1.73m2 or ≥60ml/min/1.73m2.
  Where eGFR is **above or equal to 60ml/min/1.73m2**, no further assessment is required, unless the Service User is diagnosed with hypertension or diabetes mellitus. In this case, their risk of kidney disease will be monitored as part of the management of their hypertension and/or diabetes.
  Where eGFR is **below 60ml/min/1.73m2**, further assessment for CKD is required in line with NICE clinical guideline 182 on CKD. In people with a new finding of reduced eGFR, the eGFR should be repeated within two weeks to confirm that it is abnormal. This is the responsibility of the GP or primary care nurse.
  Key points: a venous blood sample is required for this test. NPT is not considered appropriate. A serum creatinine test should be requested from the laboratory. This can be requested at the same time as a cholesterol test from the laboratory (if NPT is not used to assess cholesterol).

- **PHYSICAL ACTIVITY LEVEL** - inactive, moderately inactive, moderately active or active

  For the Physical activity assessment, a validated tool is recommended, such as DH's General Practitioner Physical Activity Questionnaire (GPPAQ) to measure the activity levels of Service Users.
  GPPAQ has been tested and validated for self-completion. It provides a measure of an Service User's physical activity levels, which have been shown to correlate with cardiovascular risk, classifying people as inactive, moderately inactive, moderately active, and active.

  NICE guidance on physical activity interventions recommends that primary care practitioners should take the opportunity, whenever possible, to identify inactive adults. The UK Chief Medical Officer recommended that all adults should be physically active daily. Over a week, activity should add up to at least 150 minutes. For further information please see:
  https://www.nice.org.uk/guidance/qs84

  Thresholds: a brief intervention on physical activity can help support Service Users to become and remain active and will be appropriate for the majority of people who fall into all GPPAQ classifications other than active.
  A brief intervention on physical activity can help support people to become and remain active and will be appropriate for the majority of people who fall into all GPPAQ classifications other than active. Service Users who are identified as inactive could be considered for exercise referral where local services exist.
  Key points: If Service Users are not achieving recommended physical activity levels, practitioners should:
  - offer to provide information on the recommended physical activity levels
  - discuss, taking into account the Service User's circumstance, preferences and health status, what the Service User might do to become more active and agree goals
  - provide written information about the various types of activities and the local opportunities to be active
  - for those who are sedentary or inactive with a health condition or risk factors, refer them to an exercise referral programme
  - follow up at appropriate intervals over a 3 to 6 month period

  Further guidance is included in Section 5 of Best Practice Guidance.

- **ALCOHOL USE ASSESSMENT** – using alcohol use disorders identification test (AUDIT) score.
  - Here is a link to the Audit-C questions Alcohol_use_disorders_identification_test_for_consumption__AUDIT_C_.pdf (publishing.service.gov.uk) Initial assessment threshold: (AUDIT-C >5) If the individual scores five or more using AUDIT-C, the second phase should be undertaken.

  Full AUDIT: if the Service User scores above the initial assessment threshold then the second phase is to complete the remaining questions of the full AUDIT. It is this full AUDIT score that can identify the risk level of the Service User.

AUDIT threshold: > 8. If the total AUDIT score from the full ten questions is eight or more, this indicates the Service User's consumption of alcohol might be placing their health at increasing or higher risk of harm. The AUDIT score should be recorded and fed back to both the individual and, where the risk assessment is carried out outside the Service User's GP practice, to the Service User's GP.

Related stages of the check: although this is not a mandated requirement, if the Service User meets or exceeds the AUDIT threshold of eight, they should be given brief alcohol advice to reduce their health risk and to help reduce alcohol related harm. A referral to alcohol services should be considered for those Service Users scoring 20 or more on AUDIT.

- New UK alcohol guidelines were published in January 2016 which recommend a lower threshold of alcohol units for men. The guidelines now state that both men and women should not regularly exceed 14 units per week to keep their risk of alcohol-related harm low. As a result, PHE reviewed the recommended screening tools (AUDIT-C, FAST and full AUDIT) and concluded that no changes are needed to these tools.
- Further Alcohol resources can be found here: Alcohol and drug misuse prevention and treatment guidance - GOV.UK (www.gov.uk

Advice to reduce alcohol use is an essential part of helping people manage the risk alcohol poses to their health and the risk of developing disease in the future. Evidence suggests this advice is most effective when delivered immediately or as soon as possible after the AUDIT assessment – the 'teachable moment'. This advice just takes a couple of minutes and consists of:

- **understanding alcohol units** – ensuring the Service User understands how much they are drinking
- **understanding risk levels** – explaining the lower-risk guidance and how the health risk rises above this level
- **informing them of their level of risk** – informing the Service User of their AUDIT score (a mandatory requirement), what risk level this indicates and where their risk level compares to the rest of the population
- **benefits of cutting down** – explain some of the benefits that could come from reducing their alcohol consumption.
- **tips for cutting down** – providing the individual with a menu of things they could try to cut back on their alcohol consumption
- This brief advice could be supported by an information leaflet or booklet given to the individual to reinforce the brief advice given and for future use.
- Providing information and brief advice on lower-risk drinking is also recommended as part of the guidance on lifestyle interventions within the NICE clinical guideline on hypertension and NICE public health guidance on preventing harmful drinking.

- **DIABETES RISK ASSESSMENT**

Best Practice guidance now recommends using a Diabetes Risk Score. This is instead of the diabetes filter, but it still identifies who will require a HbA1c test.

Gateshead is using the Diabetes UK Risk Score (Leicester risk assessment score)

Data required: The data required:- age, gender, ethnicity, family history of diabetes, BMI, diagnosis of hypertension, waist circumference,

Service Users should be considered as being at higher risk of type 2 diabetes using the following thresholds for the validated risk assessment tool:

- Diabetes Risk Score / Leicester risk assessment score is greater than or equal to 16

In addition to Service Users meeting the high-risk filter criteria, it is important to consider the situation of the Service User, because some people who do not fall into the filter categories will still be at significant risk. This includes:

- people with first-degree relatives with type 2 diabetes or heart disease
- people with tissue damage known to be associated with diabetes, such as retinopathy, kidney disease or neuropathy
- women with past gestational diabetes
- those with conditions or illnesses known to be associated with diabetes (e.g. polycystic ovarian syndrome or severe mental health disorders)
- those on current medication known to be associated with diabetes (e.g. oral corticosteroids)

Key points: The assessment of diabetes risk should be undertaken in 2 stages. The first step should be to use a validated risk tool) to identify people at risk. The second step involves performing a blood test to confirm whether a Service User has or is at risk of type 2 diabetes. As with the other tests in the check, it is important that those people who do not go on for further testing understand that everyone has some level of risk. They should also be made aware of the risk factors for diabetes as part of the general lifestyle advice that should be offered to everyone having a check regardless of their risk.

Related stages of the check

- Service Users who are identified as being at high risk of type 2 diabetes should receive a HbA1c test,

  This is to identify people at high risk of developing, or living with undiagnosed diabetes, and to undertake the necessary HbA1c test. Only those identified as at higher risk should have a HbA1c test as part of their NHS Health Check risk assessment; it is not considered clinically effective or cost effective to test everyone.

NDPP Healthier You: NHS Diabetes Prevention Programme

If the individual's fasting plasma glucose (5.5 – 6.9 mmol/l) or HbA1c (42 – 47 mmol/mol or 6% – 6.4%) indicates non-diabetic hyperglycaemia, there is very robust evidence that intensive lifestyle interventions in these individuals substantially reduces the risk of developing Type 2 diabetes.

The Healthier You NHS Diabetes Prevention Programme is an evidence-based lifestyle change programme which helps people at high risk of Type 2 diabetes to

reduce their risk through managing their weight, eating more healthily and being more physically active. Eligible patients can be referred to the Healthier You NHS Diabetes Prevention Programme via their GP practice. Patients can find out their risk of type 2 diabetes here Diabetes UK – Know Your Risk of Type 2 diabetes If risk score comes back as 'at risk', patients can sign up to the free local Healthier You programme via self-referral.

- **DEMENTIA**

  Up to 30% of dementia is attributable to risk factors including physical activity, healthy diet, reduced alcohol intake, and smoking. Therefore, everyone who has an NHS Health Check should be made aware that the risk factors for cardiovascular disease are the same as those for dementia. This can be as simple as letting Service Users know that what is good for the heart is good for the brain. E-learning materials which provide support on talking about dementia are available to practitioners.

  In addition to letting people know that the risk factors are the same, everyone aged 40-74 who has an NHS Health Check should be made aware of dementia risk reduction messaging, the signs and symptoms of dementia and be signposted to memory services if this is appropriate. The dementia component of the NHS Health Check does not require any formal assessment or memory testing. The purpose of the intervention is to raise awareness of:
  - how people can reduce their risk of getting dementia and slow its progression
  - the availability of memory services that offer further advice and assistance to people who may be experiencing signs and symptoms of dementia

  AN NHS Health Check Dementia leaflet is available to order/download, and also training materials for those carrying out the check have been produced to support this (see below).

  Resources on Dementia Risk Reduction
  - A 'Top Tips' paper for NHS Health Check providers, practitioners and commissioners on talking about Dementia in the NHS Health Check from age 40-64 years is available on the NHS Health check website.
  - The NHS Health Check Dementia leaflet can be found here. It is available in a number of different languages to order and to download
  - The revised NHS Health Check 30 minute e-learning for practitioners to introduce the dementia risk reduction component, updated January 2018
  - A page providing links to Training tools and resources

  These include:
  - 3 Videos-1) Dementia and the NHS Health Check; 2) Delivering the dementia component; 3) A walk through the dementia leaflet
  - A slide set on 'Helping your brain to stay healthy'
  - NHS Health Check Dementia Component-Prompt sheet for Health Care Practitioners
  - References and statistics to support the dementia NHS Health Check slide deck
  - How to use the NHS Health Check dementia leaflet in your appointments

There is also a video with Angela Rippon which highlights ways to reduce the risk of developing dementia. We are currently in the process of updating the 30 minute dementia online training resource for health professionals.

Dementia message risk reduction / consultation In October 2017, a consultation was undertaken on ESCAPs recommendation to include dementia risk reduction messaging as a mandatory part of every NHS Health Check. The outcome of the consultation is that Dementia risk reduction messaging to be included in the NHS Health Check, for everyone eligible aged 40-74.Further guidance from PHE is expected at the end on April 2018.

- **CARDIOVASCULAR RISK SCORE USING QRISK2**

  New guidance on QRisk2 - **QRisk2**

  During an NHS Health Check, QRISK® 2 should be used to calculate a Service User's 10-year risk of developing cardiovascular disease.13 Risk calculators and clinical decision algorithms such as QRISK®2 that meet the definition of a medical device are required to be CE marked as a medical device in line with the medical device directives. NICE (2014) Lipid modification: cardiovascular risk assessment and the modification of blood lipids for the primary and secondary prevention of cardiovascular disease www.nice.org.uk/Guidance/CG181

  Key Points: As QRISK® 2 is considered a medical device, its developer (ClinRisk Ltd) must state its intended purpose and give clear instructions for its use. Additionally, system providers e.g. EMIS, or other specialist third party suppliers of NHS Health Check solution software which integrates QRISK® 2 tool, must use this information and perform due diligence checks to ensure that it is functioning appropriately.

  This means that if a locally customised General Practice clinical system template, which:

  - has not been licenced from ClinRisk Ltd (who develop and maintain QRISK®2); or
  - has gone through the Medicines and Healthcare Products Regulatory Agency (MHRA) medical device process is being used, there is a high risk that it does not use the correct clinical codes necessary to ensure that the device functions accurately. If NHS Health Check commissioners or providers have produced and are using locally modified clinical templates, then it is advised to: Undertake assurance checks to determine whether the output from any such customisation, is in line with the developers intended purposes and their instructions for use, and any output generated as a result of using a customised template has been clinically assured and validated. Until this assurance has been obtained, the templates should be removed from use and all users informed until the relevant assurances are in place
  - if any templates have been used which are not compliant with the assurance requirement(s) i.e. give results which cannot be validated with national standards (SCCI0129 and SCCI0160); a clinical safety investigation should be undertaken
  - adverse incidents identified involving QRISK® 2 or any software medical devices should be reported via the MHRA yellow card system: www.mhra.gov.uk/yellowcard and to NHS England

Additional Guidance

- Medical device stand - alone software applications (including IVDMDs). Medicines and Healthcare Products Regulatory Agency.
- QRISK®2-2017 risk calculator ClinRisk
- Clinical Risk Management: its Application in the Manufacture of Health IT Systems. (SCCI0129) NHS Digital
- Clinical Risk Management: its Application in the Deployment and Use of Health IT Systems (SCCI0160) NHS Digital

The Service User's risk is then calculated, using QRisk2, with the results communicated by the Provider to the Service User in a way that the Service User understands. NB only QRisk2 should be used; any other risk assessments will not qualify as an NHS Health Check and will not attract a payment. In the lifestyle risk management part of the NHS Health Check, the risk score is communicated to the Service User. The results will be discussed and lifestyle advice and support offered. This will be tailored to the Service User's results and may involve a brief intervention.

- All Service Users having an NHS Health Check are to receive healthy lifestyle advice on how to maintain/improve their vascular health and reduce their risk of developing CVD.

All Service Users will receive a copy of their results in a suitable language and format using the Gateshead standardised results letter. The results letter is on the clinical system in the shared folder.

- The Provider will actively involve the Service User in agreeing what advice and/or interventions are to be pursued and encouraged/supported to develop a behaviour change action plan (goal setting)
- Any decisions made or tests/measurements undertaken by the Provider must be in partnership with the Service User and with the Service User's informed consent and recorded on the Primary Care record.

Cardiovascular disease (CVD) risk should be communicated using every day, jargon-free language. Service Users should be offered information about their absolute risk of CVD and about the absolute benefits and harms of an intervention over a ten-year period. NICE guidance advises that:

- the decision whether to start statin therapy should be made after an informed discussion between the GP or nurse and the Service User about the risks and benefits of statin treatment, taking into account additional factors such as potential benefits from lifestyle modifications, informed patient preference, comorbidities, polypharmacy, general frailty and life expectancy

CARDIOVASCULAR RISK SCORE BELOW 10%

- Service Users identified as being at less than 10 percent risk of developing CVD should be recalled after five years yet may also need lifestyle interventions to maintain or improve their vascular health (e.g., referral to a stop smoking service, advice regarding weight management or physical activity interventions)

CARDIOVASCULAR RISK SCORE OVER 10%

- Service Users with a 10% or greater ten-year risk of developing CVD should be offered appropriate lifestyle advice and behaviour change support in relation to increasing physical activity, smoking cessation, safe alcohol consumption and healthy diet
- Service Users with high CVD risk should be advised that the potential benefits from lifestyle modifications will also reduce their risk of dementia
- Where lifestyle modification has been ineffective or is inappropriate, Service Users with a 10% or greater ten-year risk of developing CVD should be offered statin therapy for the primary prevention of CVD
- NICE guidance advises that: the decision whether to start statin therapy should be made after an informed discussion between the GP or nurse and the individual about the risks and benefits of statin treatment, taking into account additional factors such as potential benefits from lifestyle modifications, informed patient preference, comorbidities, polypharmacy, general frailty and life expectancy
- If a Service User agrees to statins, they will be considered as being managed and will not be eligible for further NHS Health Checks. If the Service User refuses statins, they will be eligible for an NHS Health Check in five years

  Key point: Service Users that are either prescribed a statin or have a CVD risk score ≥20% should exit on to an at risk register

  Referral is to be made by the Provider as appropriate to GP, Lifestyle services or other appropriate services
  All results, advice, referrals and interventions are to be recorded on the primary care record.

RESULTS AND RISK MANAGEMENT

- Results should be communicated verbally and using the standardised results letter, which includes a section to record goal setting information. This is for all NHSHC's (POCT and Non-POCT). NEW REQUIREMENT for 2018/19 to use the Council standardised results letter. The results letter is on the Providers clinical system in the shared folder.
- The Provider should offer all Service Users sufficient time to conduct the full risk assessment, communicate the results in a way the Service User understands and offer ongoing referral to relevant lifestyle support services. National guidance indicates that the full NHS Health Check takes around 20-30 minutes to complete.
- The presence of other conditions that increase CVD risk are also to be recorded during the consultation i.e. rheumatoid arthritis, premature menopause, (before the age of 45) erectile dysfunction.

Everyone who has an NHS Health Check, regardless of their risk score, should be given clinically appropriate lifestyle advice, to help them manage and reduce their risk. So, unless it is deemed clinically unsafe to do so, everyone having the check should be provided with individually tailored advice that will help motivate them and support the necessary lifestyle changes to help them manage their risk. This

approach echoes the competencies set out in Making Every Contact Count (MECC). MECC enables the opportunistic delivery of consistent and concise healthy lifestyle information to individuals at scale.
The assumption is that delivering health messages should encourage people to cease or adopt certain behaviours, which in turn is likely to result in health improvement. In the context of cardiovascular disease prevention, behaviour change services are often linked to modifiable cardiovascular disease risk factors that can be managed by changes to an individual's lifestyle. Individual-level behaviour change interventions can be delivered through different methods, including:

- brief advice
- brief interventions
- motivational interviewing

The approaches are not mutually exclusive, brief interventions may contain brief advice and may use a motivational interviewing approach.
Depending on the delivery model in place, this advice and the completion of the risk assessment may be completed by different professionals. So, it is important that information such as smoking status, blood pressure, levels of physical activity and history of vascular disease in the family is transferred in written form between individuals and within the delivery team as necessary. This will help ensure continuity of care and a positive experience for the individual having the check. This is especially important for the quality of NHSHC's using Non-POCT.

For further information on Risk management and Lifestyle interventions please see Chapter 5 of the NHS Health Check Best Practice Guidance. For further information on Risk management and secondary prevention please see Chapter 6 of the NHS Health Check Best Practice Guidance.

Referral Guidance

Risk Factor	Results	Action
CVD Risk Score (QRISK)	**Lower Risk <10%**	• Provide tailored lifestyle advice based on the assessment results. • Inform Service User both verbally and in writing that that service users do not need to seek further follow up from their GP and will not need another Heath Check for 5 years.
	Higher Risk 10-19%	• Advise & reinforce healthy lifestyle. • Treatment with statins may be recommended in addition to lifestyle changes. If Service User agrees to statins they will not be eligible for further Health Checks. (Pharmacy to refer to Primary Care)

	High Risk ≥20%	• Service User should be transferred to the appropriate treatment pathway in Primary Care, in addition to lifestyle changes and are not eligible for further NHS Health Checks. (Pharmacy to refer to Primary Care)

Total Cholesterol (TC)	**TC/ HDL ratio >4mmol QRISK below 10%**	• Offer healthy lifestyle advice, particularly focusing on smoking, alcohol intake, diet and physical activity
	TC/ HDL ratio >4mmol QRISK 10% or above	• Offer healthy lifestyle advice, particularly focusing on smoking, alcohol intake, diet and physical activity • Refer service user to Primary Care to discuss the use of stains.
	≥ 7.5mmol/l	• Regardless of CVD risk the patient should be referred to their GP for Familial Hypercholesteroleamia screening within 2 weeks

Blood Pressure	**≥ 180/110**	• Take second reading during the assessment. If second reading is ≥ 180/110 recommend client makes a same day referral to their GP or visit A&E
	≥ 140/90	• Take second reading during the assessment. If second reading is ≥ 140/90 client requires an assessment for hypertension. Refer to GP

Alcohol consumption	**Audit C score <5**	• Reinforce healthy lifestyle • Raise awareness of safe drinking
	Audit- C score ≥5	• Ask remaining Audit questions. • If score is ≥8 client is at increased risk, raise awareness of safe drinking
	Audit C score >20	• Consider referral to specialist services

	Low Risk 0-6	One in 20 people with low risk will get Type 2 diabetes in the next 10 years
	Increased risk 7-15	1 in 10 people with your risk get diabetes in the next 10 years, provide brief advice

Diabetes		
	Moderate risk 16-24	One in seven people with moderate risk will get Type 2 diabetes in the next 10 years,. If score is ≥16refer to GP for HbA1c test. Patient may be eligible for NHS Diabetes Prevention Programme.
	High risk 25-47	1 in 3 people with your risk will get Type 2 diabetes in the next 10 years. Refer to GP for HbA1c test. Patient may be eligible for NHS Diabetes Prevention Programme.

Further references for applicable national standards
Best Practice Guidance
National NHS Health Check Best Practice Guidance (Oct 2019)
https://www.healthcheck.nhs.uk/commissioners-and-providers/national-guidance/

Revised NHS Health Check information governance data flows (October 2016) NHS Health Check IG and data flows pack - Oct 2016*
*Please note this guidance was developed before GDPR guidance and is due to be reviewed

Information on the national NHS Health Check Competence Framework can be found here:
http://www.healthcheck.nhs.uk/commissioners_and_providers/training/competence_framework_supporting_workbooks/
NHS Health Check Programme Pathway Diagram can be found here:
http://www.healthcheck.nhs.uk/commissioners_and_providers/delivery/

NICE Guidelines
Lipid modification - July 2014
NHS Health Check Briefing (LGB15)
https://www.nice.org.uk/advice/lgb15/chapter/Introduction Feb 2014
Type 2 Diabetes: prevention in people at high risk (PH38)
https://www.nice.org.uk/guidance/ph38 July 2012
Hypertension in adults (CG127) https://www.nice.org.uk/guidance/cg127
August 2011
Cardiovascular disease prevention (PH25)
https://www.nice.org.uk/guidance/ph25June 2010
Alcohol-use disorders: Prevention (PH24) https://www.nice.org.uk/guidance/ph24
June 2010
Chronic Kidney Disease (CG182) Jan 2015 https://www.nice.org.uk/guidance/CG182
Obesity (CG189) November 2014 https://www.nice.org.uk/guidance/cg189
Smoking: brief interventions and referrals (NG92) March 2018
https://www.nice.org.uk/guidance/ng92

Other relevant publications:
Please see NHS Health Check Best Practice Guidance Page 58 for the most up to date best practice. NHS Health Check - National guidance

The Public Health Trainer (Public Health, Gateshead Council) provides support to Providers on all aspects of NHSHC. Ian Black on Tel: 0191 433 3563 or Ianblack@gateshead.gov.uk. For queries on other areas of Health Checks, please contact Helen Bell, Public Health Programme Lead for NHS health checks. Tel: 0191 433 3628 or Helenbell@gateshead.gov.uk